Texas Department of Insurance, Division of Workers' Compensation
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address: Hubert Ratliff, MD 7502 Greenville Ave., Ste. 600 Dallas, TX 75231	MFDR Tracking #: M4-08-1030-01 DWC Claim #: Injured E
Respondent Name and Box #: Fidelity & Guaranty Insurance Box # 19	Date of I Employe Insurance

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: "Billed per Advisory 2004-06; Required testing for RTW/EMC exam; and Carrier requested IME."

Principle Documentation:

1. DWC 60 package
2. CMS 1500(s)
3. EOB(s)
4. Total amount sought $745.76

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: "After further review of its file, the Carrier issued payment on October 3, 2007 in the amount of $767.58, check number 143469775, for date of service of October 12, 2007."

Principle Documentation:

1. Response to DWC 60

Date(s) of Service	Denial Code(s)	CPT Code(s) and Calculations	Part V Reference	Amount Due
10-12-06	B5	99456-RE-59- Evaluation for MMI/IR	1-4	$350.00
	B5, 147	99456-RE	1-4	$350.00
	B5, W1	95851 (X2)	1, 5	$45.76
Total Due:				$745.76

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code Section 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division Rule 134.202, titled *Medical Fee Guideline* effective August 1, 2003, set out the reimbursement guidelines.

On 4-2-08, the Division contacted the Requestor and verified that services remain unpaid and in dispute.

1. These services were denied by the Respondent with reason code "B5-Payment adjusted because coverage/program guidelines were not met or were exceeded; 147-Provider contracted/negotiated rate expired or not on file; and W1-Workers Compensation State Fee Schedule Adjustment."

2. According to Rule 134.202(e)(7), "Return to Work (RTW) and/or Evaluation of Medical Care (EMC) Examinations. When conducting a commission or insurance carrier requested RTW/EMC examination that is not for the purpose of certifying MMI and/or assigning an IR (e.g., a medical necessity issue), the examining doctor shall bill and be reimbursed using the "Work related or medical disability examination by other than the treating physician..." CPT code with modifier "RE." The reimbursement shall be $350.00 and shall include commission-required reports. Testing that is required shall be billed using the appropriate CPT code and reimbursed in addition to the examination fee."

3. Advisory 2004-06, issued on May 12, 2004, stated in part that, "A carrier may request a doctor to perform an examination of the injured employee to determine the ability of the injured employee to return to work, to evaluate the medical care of the employee, or both. If the carrier asks, in a single request, for the doctor to both evaluate the medical care and to determine the ability of the injured employee to return to work, the doctor may bill and be reimbursed for each evaluation, both of which occurred in a single examination. In such cases, the doctor may use modifier"59" to indicate that the services performed to complete the carrier's request were distinct or independent, but appropriate under the circumstances."

4. On this date, the Requestor billed $350.00 for CPT code 99456-RE-59 + $350.00 for 99456-RE + $45.76 for 95851. Per Advisory 2004-06, the Requestor performed two evaluations and utilized modifier-"59" to differentiate it from a single evaluation. Therefore, Per Rule 134.202(e)(7), the Requestor is entitled to $350.00 + $350.00 = $700.00 for CPT codes 99456-RE and 99456-RE-59. The insurance carrier paid $0.00. The Requestor is entitled to additional reimbursement of $700.00.

5. According to Rule 134.202(e)(7), "Testing that is required shall be billed using the appropriate CPT code and reimbursed in addition to the examination fee." On this date, the Requestor billed CPT codes 99456-RE and 99456-RE-59 for the examination and CPT codes 95851 for the testing.

6. Per Rule 134.202(b), the maximum allowable reimbursement, (MAR), is determined by locality. A review of Box 32 on CMS-1500 indicates that the zip code 76708 is the locality. This zip code is located in McLennan County. The MAR for CPT code 95851 in McLennan County is $22.88 X2 = $45.76, this amount is recommended.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Section. 413.011(a-d), Section. 413.031 and Section. 413.0311
28 Texas Administrative Code Section. 134.1, Section. 134.202
Texas Government Code, Chapter 2001, Subchapter G
Advisory 2004-06

PART VII: DIVISION DECISION AND/OR ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Section 413.031, the Division has determined that the Requestor is entitled to reimbursement. The Division hereby **ORDERS** the Carrier to remit to the Requestor the amount of $745.76 plus applicable accrued interest per Division Rule 134.130, due within 30 days of receipt of this Order.

ORDER / DECISION:

Authorized Signature | Medical Fee Dispute Resolution Officer | 4-22-08 Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.